AMENDMENT OFFERED BY MR. COBURN TO THE MEDICAID RECONCILIATION PROVISIONS

(Page & line nos. Refer to the Committee Print of 6/11/97, COMSUB.RPT)

After section 3463, insert the following new section:

SEC. 3464. GRIEVANCES UNDER MANAGED CARE PLANS.

Section 1903(m) (42 U.S.C. 1396b(m)) is amended—

(1) in paragraph (1)(A)—

(A) by striking "and" at the end of clause (x),

(B) by striking the period at the end of clause (xi), and

(C) by inserting after clause (xii) the following new clause:

"(xii) such contract provides for compliance of the organization with the grievance and appeals requirements described in paragraph ( )."; and

(2) by inserting after paragraph (2) the following new paragraph:

"(3)(A) An eligible organization must provide a meaningful and expedited procedure, which includes notice and hearing requirements, for resolving grievances between the organization (including any entity

or individual through which the organization provides health care services) and members enrolled with the organization under this subsection. Under the procedure any member enrolled with the organization may at any time file orally or in writing a complaint to resolve grievances between the member and the organization before a board of appeals established under subparagraph (C).

"(B)(i) The organization must provide, in a timely manner, such an enrollee a notice of any denial of services in-network or denial of payment for out-of-network care or notice of termination or reduction of services.

"(ii) Such notice shall include the following:

"(I) A clear statement of the reason for the denial.

"(II) An explanation of the complaint process under subparagraph (C) which is available to the enrollee upon request.

"(III) An explanation of all other appeal rights available to all enrollees.

"(IV) A description of how to obtain supporting evidence for this hearing, including the patient's medical records from the organization, as well as supporting affidavits from the attending health care providers.

"(C)(i) Each eligible organization shall establish a board of appeals to hear and make determinations on complaints by enrollees under this subsection concerning denials of coverage or payment for services (whether in-network or out-of-network) and the medical necessity and appropriateness of covered items and services.

"(ii) A board of appeals of an eligible organization shall consist of—

"(I) representatives of the organization, including physicians, nonphysicians, administrators, and enrollees;

"(II) consumers who are not enrollees; and

"(III) providers with expertise in the field of medicine which necessitates treatment.

"(iii) A board of appeals shall hear and resolve complaints within 30 days after the date the complaint is filed with the board.

"(D) Nothing in this paragraph may be construed to replace or supersede any appeals mechanism otherwise provided for an individual entitled to benefits under this title.".